Durable Medical Equipment
Authorization Request Form
Please fax with supporting medical documentation
800-215-4901

Effective January 3, 2005, all Prior Authorization requests must either be faxed on this template or be submitted through the Medical Authorization Entry screen on the Web Bill Processing Portal (http:\\owcp.dol.acs-inc.com). **All fields are required and must be complete. Incomplete requests and requests that are not properly coded with CPT or HCPCS cannot be processed and will be returned.**

Date Requested _____ Requested by _____

Case file # _____

Claimant Name _____

Claimant Date of Birth (optional) _____

Provider Name _____

ACS Provider Number _____

Provider Tax ID _____

Date(s) of Service Requested _____

Procedure Code(s) and/or Modifier(s) (HCPCS) _____

_____

Rental or Purchase and price per item _____

_____

Duration Requested _____

Comments _____

_____

_____

Please remember to send prescription from attending physician and/or any supporting medical documentation for request.
Please put Case File # on every page faxed. 800-215-4901